Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: SPINECARE, LLP. 5734 SPOHN DRIVE, STE. B CORPUS CHRISTI, TX 78414	MFDR Tracking #: M4-09-8162-01
Respondent Name and Box #: BITUMINOUS CASUALTY CORP. Rep Box #: 19	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The carrier incorrectly denied our claim stating anesthesia fees are bundled together and not paid separately. Anesthesia fees are not bundled together with the facility fees and are separately reimbursed. Our office sent a request for reconsideration to the carrier after we received the first denial however the carrier is still denying our claim."

Per DWC-60 Table: "Authorization was obtained prior to services rendered. See Exhibit #6 Anesthesia is separately reimbursable."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $298.49
3. CMS 1500s
4. EOBs
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

The Respondent's Position Summary: "…The carrier asserts that it has paid according to applicable fee guidelines…All reductions of the disputed charges were made appropriately."

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
12/4/08	01992-QZ-QS-P2	B15, R78, W4	1-10	$298.49
Total Due:				$298.49

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.203, titled ***Medical Fee Guideline for Professional Services*** effective for professional medical services provided on or after March 1, 2008, set out the reimbursement guidelines.

On August 5, 2009, the Division contacted the Requestor and verified services remain unpaid.

1. The disputed service listed in Part IV of this decision was denied by the Respondent with reason codes:
    - "B15-Procedure/Service is not paid separately;
    - R78-CCI: Anesthesia included in surgical procedures; and
    - W4-No additional payment allowed after review."
2. On 11-12-08, the Respondent's representative, Corvel, gave preauthorization approval for:"Left transforaminal lumbar L4/5 ESI w/fluoroscopy & MAC anesthesia #2 (64483, 64484, 77003, 01992)."
3. Per the Anesthesia Record, the claimant underwent claimant underwent "MAC/IVG." Per NCCI edits, "Monitored Anesthesia Care (MAC) may be performed by an anesthesia practitioner who administers sedatives, analgesics, hypnotics, and other anesthetic agents so that the patient remains responsive and breathes on his own. MAC provides anxiety relief, amnesia, pain relief, and comfort. MAC involves patient monitoring sufficient to anticipate the potential need to administer general anesthesia during a surgical or other procedure. MAC requires careful and continuous evaluation of various vital physiologic functions and the recognition and treatment of any adverse changes. CMS recognizes this type of anesthesia service as a payable service if medically reasonable and necessary."
4. Per the Anesthesia Record, the surgeon was Dr. Potter and the anesthesiologist was Linda Peterson, CRNA. Per NCCI edits, "With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical service when provided by the physician performing the service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia Monitored anesthesia. Since the anesthesia was performed by a separate healthcare provider, the anesthesia service is not global to the ESIs; therefore, reimbursement is recommended per Rule 134.203.
5. CPT code 01992-QZ-QS-P2 is defined as "Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); prone position." The QZ modifier is to be used when CRNA performs anesthesia and is not medically directed. The QS modifier identifies anesthesia was for MAC services. The Requestor utilized modifier P2 to describe patient had mild systemic disease.
6. Review of 28 Texas Administrative Code (TAC) Section 134.203(a)(2) states, "This section applies to professional medical services provided on or after March 1, 2008.
7. The CMS-1500 indicates that the Place of Service is 24 – Ambulatory Surgical Center.
8. Review of 28 Texas Administrative Code (TAC) Section 134.203(c)(1) states, "…To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification…For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32…"
9. Per the Anesthesia report the start time was 9:23 and end at 9:43 for a total of 20 minutes. 20 minutes /15 minute increments are 1.33 units.
10. Per 28 Texas Administrative Code Section 134.203(b), the MAR for CPT code 01992-QZ-QS-P2 is:

    Base Unit 5 + Time Unit 1.33 = 6.33 X $66.32 conversion factor = $472.38. The Requestor is seeking a lesser amount of $298.49, this amount is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

- Texas Labor Code Section 413.011(a-d);
- 28 Texas Administrative Code Section 134.203

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $298.49 and applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

DECISION & ORDER:

		August 10, 2009
Authorized Signature	Medical Fee Dispute Resolution	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.